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EXPRESSING THE OPPOSITION OF CONGRESS TO PROPOSALS IN THE BUDGET TO REDUCE THE CAPACITY OF THE VETERANS' ADMINISTRATION TO PROVIDE HEALTH CARE TO ELIGIBLE VETERANS

FEBRUARY 26, 1987.—Referred to the House Calendar and ordered to be printed

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Mr. MONTGOMERY, from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany H. Con. Res. 27]

The Committee on Veterans' Affairs, to whom was referred the concurrent resolution (H. Con. Res. 27) expressing the opposition of Congress to proposals in the Budget to reduce the capacity of the Veterans' Administration to provide health care to eligible veterans, having considered the same, report favorably thereon without amendment, by unanimous voice vote, and recommend that the concurrent resolution do pass.

INTRODUCTION

The budget proposed by the Administration for fiscal year 1988 funding for the Veterans' Administration was presented to the Congress on January 5, 1987.

On January 21, 1987 the Chairman of the Committee, G.V. (Sonny) Montgomery, for himself and Mr. Solomon, the Ranking Minority Member, introduced H. Con. Res. 27, expressing the opposition of Congress to proposals in the budget to reduce the capacity of the Veterans' Administration to provide health care to eligible veterans.

On February 3 and 4, 1987, the Committee held hearings to receive testimony concerning the Administration's proposed budget. The Committee received testimony from the Veterans' Administration, the Paralyzed Veterans of America, the Disabled American Veterans, the AMVETS, the Veterans of Foreign Wars, The American Legion, the Vietnam Veterans of America, and a panel of Veterans' Administration executive health care professionals.

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On February 19, 1987, the Committee met to consider recommendations to the Budget Committee and H. Con. Res. 27. By a unanimous voice vote, the Committee, with substantially more than a quorum present, ordered H. Con. Res. 27 to be reported to the House.

DISCUSSION OF THE RESOLUTION

H. Con. Res. 27, as reported, would express the strong opposition of the Congress to the policy contained in the Veterans' Administration proposed budget for fiscal year 1988 which would reduce capacity of the Veterans' Administration to provide health care to eligible veterans through a reduction in funding levels.

In order to maintain the high quality of care delivered in its comprehensive medical care delivery system, the Department of Medicine and Surgery must furnish a new mix of services in response to an aging veteran population, a changing demographic distribution of veterans, new medical technology, and shifts in the practice of medicine toward outpatient treatments, all within the constraints of an aging capital plant. At the same time, the Department of Medicine and Surgery must continue to meet the needs of all eligible veterans including those with routine medical care needs, as well as those with special needs such as AIDS.

The Committee believes that actions proposed in the Administration's budget are inconsistent with the decades-old commitment of this Nation to its veterans and with the diverse and changing demands on the VA's medical care system. In particular, the Committee opposes the following features of the proposed VA budget: (1) elimination of funds for providing care to Category C veterans, (2) arbitrary "productivity increases", (3) insufficient extended care resources, (4) inadequate outpatient care resources, and (5) inadequate response to special populations such as AIDS and the homeless.

Medical care for Category C veterans

The Committee views with strong disfavor two features of the Administration's proposed fiscal year 1988 VA medical care budget which are predicated on a policy of eliminating funding for the costs of care provided to veterans eligible under Category C. First, there is a proposed rescission of $75 million in fiscal year 1987 funds; and second, there is a proposed decrease in fiscal year 1988 funds of $92.186 million. Taken together the proposal to eliminate funds for Category C veterans would result in a decrease of 1,400 medical FTEE in fiscal year 1987 and 2,350 FTEE in fiscal year 1988 for a cumulative decrease of 3,750 FTEE. Such decreases would seriously reduce the capacity of the VA to deliver health care. As a practical matter, this policy is inconsistent with Congressional intent which allowed care to be furnished to such veterans if resources and facilities were available and if the veteran were to agree to make certain copayments to the VA.

Title XIX of Public Law 99-272, Veterans Benefits and Services Provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986, revised the eligibility for VA medical care benefits. The

Act, as implemented by the VA, established three groups of VA health-care eligibilities particularly with regard to hospital care.

The first group (now known as Category A) is *required* to be provided needed hospital care through VA facilities, and in non-VA facilities within certain restrictions. Category A veterans include: veterans with service-connected disabilities; former prisoners of war; veterans exposed to certain herbicides and ionizing radiation; veterans disabled as a result of VA medical treatment or vocational rehabilitation; veterans of the Spanish-American war, Mexican border period, of World War I; and non-service-connected veterans with one dependent whose income does not exceed $18,234 (or $15,195 for a single veteran) increased by $1,013 for each dependent in excess of one.

The eligibility for care for veterans in Categories B and C within the available resources is intended—and historically has been intended under various eligibility arrangements—to ensure that the VA medical care system is fully utilized. The reason for building in this flexibility is that demand for medical care is random; that is, no one can predict exactly on a given day how many people will need and apply for care. Over time it is possible to mathematically predict *on the average* how many beds a defined population may need, but from day to day the capacity to provide care may vary from no extra beds available to many extra beds available. Random demand occurs with other factors of medical care also. Thus, at a given time, after Category A veterans have been treated, any extra capacity, often referred to as "available resources", is expressly to be used by Category B and C veterans.

The obvious difficulty in implementing the proposed policy of cutting funds in the amount necessary to provide Category C care but not refusing Category C veterans outright is this: the order in which veterans apply for care is also random. That is, Categories A, B, and C veterans arrive in mixed order both during a given day and during the year. Not all Category A veterans seek care, followed by Category B veterans and so on. Indeed, it is theoretically possible for all Category C veterans to apply for care before all Category A veterans. The decision to treat a Category C veteran depends on the existence of available resources and the perception that resources are sufficiently available in the future to care for all Category A veterans. The practical result of the proposed policy is obviously the denial of some medical care to all categories of veterans with the increased possibility of denial of care to the Category C veteran.

Medical care program management

In addition to the proposals concerning Category C veterans, the Administration's proposed budget for fiscal year 1988 also includes a repetition of the "one percent productivity increase" which accounts for a decrease of $58.297 million and 1,911 FTEE in fiscal year 1988. In testimony before the Committee, medical officials of the Department of Medicine and Surgery have testified that such productivity increases are not a result of rational, planned improvements in efficiency. Instead, the decreases are simply percentage reductions taken from budget allocations to the medical centers, thus reducing the amount of care that can be delivered to eli-

gible veterans. Indeed, a look at the budget history of the VA shows the dramatic results in increased productivity already achieved by the Department of Medicine and Surgery. Since 1977, while the VA budget has remained at a straight line, the number of inpatients treated has grown by over 10 percent and the number of outpatient visits has grown by over 20 percent.

In noting the increased productivity already obtained by the VA, the Committee opposes further decrements to the budget under the guise of arbitrary productivity improvements. Instead, the Committee believes that further productivity increases should reflect actual, specific initiatives demonstrated to result in real productivity increases. Without such real initiatives, further productivity increases will only reduce the capacity of the VA to deliver medical care.

Extended care

The projected increase in the elderly population of the United States is being experienced earlier in the veterans population than in the general population. The number of veterans over the age of 65 was 4.6 million in 1985 and is predicted to increase to 7.2 million by 1991 and to peak at 8.9 million veterans in 1999. Sixty percent of all males over the age of 65 will be veterans in 1991. In 1999, 3.8 million of the projected 8.9 million veterans will be over the age of 75 and in 2031 3.7 million veterans will be over the age 75, forming a much larger proportion of the veteran population than age group does today.

It is, therefore, almost trite to observe that the VA's capacity to deliver long term care services must increase in terms of nursing home beds, domiciliary beds, and State veterans home beds. An important change in the VA's policy relative to long term care is seen in the stated goal that 30 percent of the need for long term care beds should be met by VA-owned and -operated beds, 30 percent of the need should be met by State veterans home beds and 40 percent should be met by community beds. The estimated proportions among these three categories for fiscal year 1988 are: 35 percent in VA-owned and -operated units; 28 percent in State homes; and 37 percent in community facilities. Overshadowing these statistics are the long waiting lists and the numbers of veterans needing long-term care who today are turned away.

Notwithstanding the great need, the Administration proposes an increase of only 741 additional VA nursing home census in fiscal year 1988 through three actions: (1) conversion of beds from acute care use to nursing home care use, (2) realignment of funds from hospital use to VA nursing home use, and (3) activation of new facilities. The Administration also proposes an increase of only 734 census in State homes for fiscal year 1988. However, the increase in census in VA nursing home care units and State homes, as noted in the Administration's budget documents, "* * * is offset by the reduction in workload * * *" in other areas.

The Committee believes that the magnitude of the Administration's proposal is clearly insufficient to meet the anticipated need for extended care, even assuming that the utilization rate of VA medical services does not increase.

Outpatient care

The steady rise in demand for VA outpatient care has resulted from changes in the practice of medicine and the increasing aging veteran population. The locus for many medical procedures is now in an outpatient setting. This is cost-effective due to the avoidance of expensive inpatient fixed costs. It also allows less expensive services to be delivered far from the medical center through satellite outpatient clinics and mobile outpatient teams, a clear advantage to rural or geographically isolated veterans. In addition, the delivery of outpatient services may reduce the number of hospital admissions and the duration of inpatient episodes through the maintenance of stable chronic conditions. The turning away of over 35,000 veterans each month and excessively long waiting lists for many types of outpatient care is clear evidence of the need for increased outpatient capacity.

Special populations

The Administration's proposed budget does not reflect the large and growing costs associated with the treatment and care of veterans with AIDS. Such an omission amounts to a reduction in VA medical care capacity in light of the financial burden of caring for veterans with AIDS. Currently, the VA is treating approximately 1,000 of these veterans at an average annual cost of $40,000 per patient. The rate of increase of AIDS cases may not equal the annual doubling of the past few years; however, predicting the future caseload is difficult since it depends on the mortality rate as well as the incidence rate. Due to the wide range of diseases in which AIDS manifests itself, the VA's resource allocation model allocates funds among hospitals in ways that are not related to the actual costs of treatment. In addition, under current VA practice, VA medical centers with fewer than 10 AIDS patients must absorb the costs. Despite claims made in the VA's budget documents, there are no new dollars in the Administration's request for treatment of veterans with AIDS.

The Administration's proposed budget does not reflect the problem of homeless veterans, an unknown proportion of whom may also suffer mental illnesses. The Committee notes that the VA has reduced the number of beds available in VA hospitals for psychiatric care and has closed approximately 6,000 domiciliary care beds. This contraction in the availability of beds for chronic and long-term patients was brought about as part of a policy of reducing the number of veteran patients who resided for long periods of time in VA facilities.

Reduction of capacity through mission changes

Four proposals in the Administration's budget are specific examples of the intent to scale down the capacity of the VA to deliver medical care: (1) closure of the surgical capability as the first phase of a mission change at Big Spring, Texas VA Medical Center; (2) a mission change from an acute care facility to a predominantly extended care center at the Miles City, Montana VA Medical Center; (3) the closure of the outpatient clinic in New Bedford, Massachusetts which is called by the Administration a "consolidation of re-

sources"; and (4) the major mission change from an acute facility to an outpatient care facility at the Walla Walla, Washington, VA Medical Center. These four proposals were not made in the context of an overall agency plan required by law.

Section 302 of Public Law 99-166 required the Veterans' Administration to submit a five-year strategic plan for each existing or proposed VA medical facility. That law specifically required three parts to be in the strategic plan: "* * * (I) the mission of each existing or proposed medical facility; (II) any planned change in such mission; and (III) the operational steps needed to achieve the facility's mission and the dates by which such steps are planned to be completed; * * *" The intent of this law was to ensure sound planning information would be available to the Congress and to the VA. Effective budgetary decisions for the VA's Department of Medicine and Surgery are severely hampered without a strategy for carrying out the responsibilities of medical services for veterans as mandated under title 38 U.S.C.

The first plan under section 302 which was due on June 30, 1986 has not been received by the Committee. In response to a letter inquiring about the specific mission changes and their relationship to the overall plan, the Administration responded: "The Department of Medicine and Surgery's overall strategic goal is to consolidate redundant programs and activities; increase sharing or contracting with cost-efficient community and other resources where the quality is consistent with the VA; eliminate lower priority and less essential services; and to increase efficiency and productivity." The Committee interprets those words to be a clear statement of the intent of the Administration to constrict VA health care. The budgetary proposals of the Administration which are discussed elsewhere in this report, the four mission changes listed above, and the noncompliance with law are all designed to reduce the capacity of the VA and, as such, are incompatible with the expressions of the Congress with regard to eligibility for VA medical services and to the range of services to be furnished.

The Committee is profoundly disappointed that the Veterans' Administration has ignored the requirements of Public Law 99-166. Not only are the requirements of this statute fundamental to effective and efficient management of a large organization, but mission changes such as the four listed above will have lasting impact on the health care delivery system of the VA. In a larger sense, the Committee believes that the Veterans Administration medical care system is a fundamental part of the medical care system of the United States, the scope of which is determined by the Congress. The Committee is considering legislation to recommend to the House which would prohibit mission changes until the VA complies with the letter and intent of the law.

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